

# Lessons From the Practice

## Borrowed Time

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**A**s we looked at a computed tomographic scan showing a grade 5 hemorrhage, Michael, a third-year medical student, bluntly asked me, "Are you going to pull the plug?"

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The patient, Frank Stern [not his real name], first visited my office eight years ago. He told me of his two heart attacks and his coronary artery bypass operation five years earlier that had permanently limited his ability to exercise. Nonetheless, he and his wife Gladys traveled extensively. He viewed his atherosclerosis as a time bomb and referred to the past five years as "borrowed time." He said that if anything happened and there was no hope of meaningful recovery, he wanted "no machines, including no artificial feeding." Frank handed me his advance directive and said, "And I've told my family how I feel."

Two years ago, Frank had a third small heart attack, and mild congestive heart failure developed. With diuretics he continued to travel and say how lucky he was to have this borrowed time.

A week ago, I got a phone call. Frank was in the intensive care unit (ICU) with a large ruptured cerebral aneurysm. I felt a knot develop in my stomach as I discussed Frank's situation with the neurosurgeon. I knew Frank would not have wanted to have anything done given the odds of death or severe brain damage, but the neurosurgeon had already operated on Frank's artery and stopped the bleeding in his head. The surgeon said he doubted that Frank would ever wake up.

I met the family at Frank's bedside in the ICU. He was connected to full life support and was totally unresponsive. I thought to myself, "This is not Frank's idea of borrowed time!"

Frank had not told his family how ill he was. It took several days for them to accept that he was not going to recover. With this acceptance came a request to remove the life support.

I talked to the family about what to expect when Frank's life support was withdrawn. I told Gladys and their son Jeff that Frank might live for a few minutes to two weeks, even if all life support, including artificial nutrition and hydration, was withdrawn. We developed a plan that focused on Frank's comfort, and I suggested that

we treat him as if he were awake while having the ventilator withdrawn. That way, we would be certain that he experienced little or no suffering.

Frank's family gathered in the ICU at 10 AM the next morning. Before I talked to them, I met with Melissa, Frank's nurse, to go over each step of the process. Melissa had already removed Frank's central line and feeding tube before the family joined us at the bedside. I asked Michael and a fellow medical student to join us to learn more about how to preside over a peaceful death.

Even though Frank was in a deep coma, before withdrawing life support I spoke to him as I usually do with my awake patients. I told Frank in the presence of his loved ones why we were stopping life support and explained what was going to happen. I find it helps lift the burden of guilt from families for me to talk to the dying patient openly about the decision and the process.

"Frank, I remember the day we met and what you told me of your feelings about medicine and machines. The other doctors and I don't think you will recover, and knowing your strong feelings, I have advised your family that it is time to respect your wishes, stop the machines, and focus on your comfort. I don't think you will survive off the machines for more than a week or two." (I said this even though I thought it would probably be only a few hours, because families sometimes find it hard to adjust to underestimates.) I ended by saying, "Frank, I am glad to have known you. You are fortunate to have such a loving family."

After wiping away a tear, I suggested that the focus of our attention should be on Frank, not the monitors. Melissa quietly reached up and turned off the monitor. I gave an additional intravenous dose of furosemide to help Frank avoid the rattling respirations that can be caused by congestive failure.

The students seemed anxious and stood tightly against the wall. I tried to include them in this intense experience at Frank's bedside. I shared with them my thoughts that Frank would be more comfortable in his breathing if he was a little dehydrated rather than fluid-overloaded. Then Melissa and I slowly gave morphine sulfate and lorazepam intravenously to control both dyspnea and anxiety. Melissa suctioned Frank once more, and he again looked uncomfortable. I gave a little more lorazepam and morphine.

I explained that if Frank survived for several hours, we

(Tolle SW. Borrowed time. *West J Med* 1997 Mar; 166:223-224)

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would move him to a private room and that the family could stay with him. Again, Melissa suctioned Frank and then she disconnected the ventilator. Frank stopped breathing for 30 seconds and turned a little blue. Then shallow, somewhat gasping respirations started at a rate of 30 per minute. I gave him an additional 5 mg of morphine, which brought his respiratory rate down to 20. He looked comfortable, and we removed his endotracheal tube. Frank died 2½ hours later.

Jeff kissed his father good-bye. He told me, "I was afraid to be at Dad's bedside when life support was withdrawn. This was so much more compassionate than I had expected." He put a hand on my shoulder and quietly said, "Thanks for taking care of my dad. He thought so much of you." I hugged Gladys. The students quietly observed, and Michael perhaps learned the difference between "pulling the plug" and the compassionate withdrawal of life support.